Guidelines for Hearing Voices Groups in Clinical Settings (2004 update)

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Introduction

These guidelines have developed from the experience of practitioners and service users who have contributed to seven years of group work for psychosis in Gloucestershire, UK.

Context

Voice hearing is often seen as a prime symptom of psychosis (American Psychiatric Association, 1994). However there are a significant proportion of the voice hearing populations that have never been psychiatric patients (Honig et al., 1998). Hearing voices (auditory hallucinations) is considered a first rank symptom of the specific psychosis of schizophrenia (Schneider, 1959). There are three main psychiatric categories of patients that hear voices; schizophrenia (around 50%); affective psychosis (around 25%) and dissociative disorders (around 80%) (Honig et al., 1998).
However, many people who hear voices find them helpful or benevolent (Romme & Escher, 1993). In a large study of 15,000 people it was found that there was a prevalence of 2.3% who had heard voices frequently and this contrasts with the 1% prevalence of schizophrenia (Tien, 1991). In a study by Honig and others (1998), of the differences between non-patient and patients hearing voices, it was not in form but content. In other words the non-patients heard voices both inside and outside their head as did the patients but either the content was positive or the hearer had a positive view of the voice and felt in control of it. By contrast the patient group were more frightened of the voices and the voices were more critical (malevolent) and they felt less control over them (Honig et al, 1998). The experience of hearing critical voices is often very anxiety provoking and leads to high levels of depression and suicidality (Harkavy-Friedman et al., 2003). Conventional approaches in psychiatry to the problem of voice hearing have been to ignore the meaning of the experience for the voice hearer and concentrate on removing the symptoms (audio hallucinations) by the use of physical means such as medication (Romme & Escher, 1989). Although anti-psychotic medication is very helpful to most sufferers of psychosis (Fleischhaker, 2002), there is a significant proportion (30 per cent) that still experience the 'symptoms' such as hearing voices despite very high doses of injected anti-psychotic (Curson, Barnes, Bamber, & Weral, 1985). The social psychiatrist Marius Romme, believes that anti-psychotic medication prevents the emotional processing and therefore healing, of the meaning of the voices (Romme & Escher, 2000). Traditional practice in behavioural psychology concentrated on either distracting the patient or ignoring references by the patient to the voice

hearing experience, with the hope that the patient would concentrate on 'real' experiences, which would then be positively reinforced (the assumption being that the voice hearing was a delusional belief). The effect of this approach may well have been to discourage the discussion about the voice hearing experience but without eradicating it (P.D.J. Chadwick, Birchwood, & Trower, 1996). However brain imaging has since confirmed that voice hearers do experience a sound as if there were a real person talking to them (Shergill, Brammer, Williams, Murray, & McGuire, 2000). Within the last ten years there has been considerable interest in the phenomenology, processes and coping mechanisms of people suffering from psychosis, using a broadly Cognitive Behavioural Therapy (CBT) approach (Drury, Birchwood, & Cochrane, 2000; Haddock, Morrison, Hopkins, Lewis, & Tarrier, 1998; Kuipers et al., 1998; Morrison, 2002; Norman & Townsend, 1999). Some practitioners advocate that CBT is the most appropriate, evidence based approach (Tarrier, Haddock, Barrowclough, & Wykes, 2002). Other practitioners, including psychiatrists, psychologists and nurses have developed a broader based alliance of therapeutic approaches to psychosis from the spectrum of approaches from psychodynamic to cognitive behavioural (Martindale & International Society for the Psychological Treatments of the Schizophrenias and other Psychoses., 2000). Radical changes have also been taking place amongst psychiatrists(Kingdon & Turkington, 1998; Perris & McGorry, 1998), who are now paying closer attention to the meaning and content of the voices (Romme & Escher, 1989).

Although group work has been reported to be a therapeutic medium by voice hearers themselves (Baker, 1995) there has been little formal use of such groups by professionals treating psychosis. The reason for this may be that group work has been steeped in psychodynamic principles, which suggested that people with psychosis were unable to benefit from participation in analytic groups where the group leader remained silent and anxiety built up in group members (Yalom, 1983). This perception is now changing and given the right conditions of a clear structure, clear boundaries, here and now focus on specific issues and an attempt to reduce anxiety at an early stage of the group work, then group work with psychotic patients can be successful in reducing symptoms as well as providing peer support (Addington & el-Guebaly, 1998; Albiston, Francey, & Harrigan, 1998; Andres, Pfammetter, Garst, Teschner, & Brenner, 2000; Buccheri, Trygstad, Kanas, Waldron, & Dowling, 1996; P. Chadwick, Sambrooke, Rasch, & Davies, 2000; Free, 1999; Gledhill, Lobban, & Sellwood, 1998; Halperin, Nathan, Drummond, & Castle, 2000; Hyde, 2001; Kanas, 1988, 1991, 1996, 1999; Levine, Borak, & Granek, 1998; O'Neil & Stockwell, 1991; Schermer & Pines, 1999; Smith, 1999; Vassallo, 1998; White & S., 2000; Wykes, Parr, & Landau, 1999; Yalom, 1983)

Philosophy and Theoretical Underpinning

Despite theoretical differences between psychodynamic approaches and CBT approaches there is now a great deal of positive overlap to the benefit of those

suffering psychosis (Schermer and Pines, 1999). Of late there has been renewed interest in using attachment theory as an approach to healing the early trauma of many sufferers (Allen, 2001) as well as new developments in such fields as drama therapy (Casson, 2004). Some psychiatrists are interested in moving from a strictly biological model of voice hearing and schizophrenia to an individual psychological approach (Leuder & Thomas, 2000). Others are interested in combining models into the bio-psycho-social approach with psychiatrists trained and working with talking therapies as well as medication (Gabbard & Kay, 2001). There are useful ideas in the self help approach of the Hearing Voices Network (Downs, 2001) but self help hearing voices groups have not been viable in Gloucestershire.

An adapted form of the stress vulnerability models has been incorporated as an explanatory framework for the voice hearing (Nuechterlein & Dawson, 1984; Zubin & Spring, 1977) that reduces the suggestion of weakness (vulnerability) and emphasises the on going ability to cope, learn and evolve competency as well as be affected by illness (Davidson & Strauss, 1992).

Overall the groups in Gloucestershire have adopted the Integrative Approach to groupwork for psychosis (Kanas, 1996). This approach emphasises reduction in isolation by increasing social interaction, learning to overcome the distress of symptoms (especially by sharing coping strategies) and being user led as to the content of sessions, so long as that is within the clear framework already negotiated. The facilitators are practitioners who use a directive approach to reduce anxiety. The group is seen as a coming together of individuals in a shared endeavour to help each other (a work group) rather than the group process bringing about change (analytic group).

Training of Facilitators

Within Gloucestershire most of the facilitators had undergone specialist training in psychosocial approaches to psychosis and were also skilled in group work. The facilitators were from the disciplines of nursing, psychology and social work and one is a service user who has co-facilitated a group in an inpatient setting.

The Process of Setting up a Group

The setting up of a hearing voices group or other group for psychosis needs to be a decision taken by the whole team. It is important that the multi-disciplinary team, users and carers take part in the setting up of the group in order to ensure ownership, support and participation in the process. Once the decision is made to start the group then contact could be made with facilitators and members from other groups, who will then explain the process and resources available.

Gender Issues

If women are present as group members then it is important that at least one facilitator is a woman (Macdougall 1998). Many people who experience voice hearing have suffered childhood trauma including bullying and sexual abuse (Read, Agar, Argyle, & Aderhold, 2003; Read, Perry, Moskowitz, & Connoly, 2001). There may be a need for a separate women's group as was the case when one of our groups grew too large as a mixed group. The women felt they had lost the ability to communicate effectively because of domination by the men. The women also felt there was too much of an emphasis on the cognitive aspects of voice hearing rather than how voice hearing impacted on family relationships.

Supervision

After each group the facilitators (two for every group) wrote up the minutes and discussed the group. Every month the facilitators meet as a group for supervision, usually for two hours. The style is informal and sharing successful interventions is encouraged. Risk issues and other more immediate needs can be addressed by calling the supervisor or other facilitators as well as normal risk management processes within the care programme approach.

Inclusion Criteria for group members

The group members:

- Are primarily distressed from hearing voices and may have other problems of psychosis
- Want to work as a member of a Hearing Voices Group
- Usually have a diagnosis of psychosis/severe mental illness such as schizophrenia, affective psychosis
- Usually have tried a variety of anti-psychotic medication with little effect on the hallucinations/voices
- May have a contact who will liaise with the group facilitators, such as a care co-ordinator or key worker.
- Where possible they will already be attending at the centre where the hearing voices group or other group for psychosis is to be held as this helps the person feel comfortable in the group. For some people it is very stressful to enter a busy day centre for the first time without knowing the people there. If they are not attending the day centre already then a careful process of engagement may be needed, depending on the person.

Exclusion criteria:

- Usually, the continued use of illegal substances such as amphetamines, heroin etc., or large quantities of alcohol excludes persons from making use of the group at this time.

Referrals

Referrals can be accepted from members of the multi-disciplinary team who would normally be the key worker of the voice hearer or sufferer from psychosis. The importance of the rest of the team is recognised. Referrals should be in writing and include a brief psychiatric history. The voice hearer should see the referral letter or copy of full CPA and agree, before it is sent to the group facilitators. A voice hearer or sufferer from psychosis should be able to refer themselves to the group and the normal process reversed in order to ensure a keyworker and MDT support. Several group members have prompted the referral of voice hearers they know need help. This has been a very successful method of introduction. Most new referrals see the group video made by group members (Coupland & Jones, 2002). They are encouraged to make an informal visit to the group before committing themselves.

Assessment

If the referral is accepted the voice hearer may be asked to attend an individual assessment. The first strategy is to normalise the voice hearing experience and put the voice hearer at their ease. The assessment is quite lengthy and makes use of the Manchester Symptom Scale, also called the KGV after the authors (Krawiecka, Goldberg, & Vaughan, 1977). The scale is very helpful in finding out how the voice hearers experience their psychotic symptoms as well as the anxiety, depression and suicidality the symptoms may cause, especially in the later versions of the scale (Lancashire, 1994). We write back to the group member with the results of the assessment, including a history of the voice hearing, so that the member can correct mistakes and co-create the final version of the assessment, a process that seems to increase the ownership of the experiences (Coupland, Davis, & Gregory, 2001). Not being able to complete a KGV does not necessarily preclude the sufferer from attending a group. A very comprehensive assessment (the Maastricht Interview) is included in the book by Romme and Escher, 2000. After the assessment a letter is sent to the voice hearer, with a copy to the care co-ordinator, explaining the outcome of the assessment and whether the person has been accepted at this point to join a group. An important part of the letter is identifying and reflecting back the coping mechanisms that the person already has as well as a provisional formulation as to how the person is affected and a plan of how the groupwork might help. Where possible assessments are repeated every three to six months.

Structure of the group

The group would normally have 6 to 8 participants and 2 facilitators. Initially, the group will meet weekly for 12 sessions followed by a break for two weeks for evaluation. After a further 12 sessions there is another evaluation period of 2 weeks. The group meets at a set time each week. The time of the sessions need to be agreed by the group along with the ground rules. Although there is evidence for of efficacy for short-term (six weeks) psycho-educational groupwork (Wykes et al., 1999) our own research suggests additional benefits of long term work. This makes the group a slow open style, with additional members joining the group in time and members leaving the group when they have jobs or move on for other reasons. Group members may need gentle encouragement over a long period to keep coming to the group.

Therapeutic process

The facilitators take an active role in running the group. They provide a high degree of structure for the early part of the group process (research and experience has shown that this is very important in order to reduce anxiety that people feel when they experience the group process). There may be a strong element of psycho-education, such as discussing what is meant by an hallucination, or a diagnosis of schizophrenia. This helps remove the feeling of being under pressure to contribute and self disclose, however the group members soon gain confidence to contribute. The early sessions should seek to establish the ground rules for running the group; the members of the HVG at Milsom St. produced the following:

Ground rules for groupwork

- All participants should have respect for the rules of the building i.e. where smoking is permissible.
- There will be a break for tea, coffee, cigarettes after 45 minutes, followed by another 30 minutes of group work.
- Confidentiality: members and staff should not share information they hear in the group about members, with people outside of the group unless for risk management reasons or where permission is given for supervision or education.
- The group should start promptly each week at the agreed time.
- The group members expect each other to attend regularly.
- The focus of the group work is the origin, content, meaning, understanding and ways of coping with the voices. This process helps us to be aware of how to deal with the voices.
- We will not criticise each other's contribution but we realise that what works for one person may not work for others.
- We aim to be supportive of each other in the group.
- Sharing is an important part of the group work.

- We will all be involved and take part in the group.
- Humour is an important part of the group, but laugh with us not at us.
- Facilitators are available for an agreed period of time after the group

The following few sessions should follow a format that gives an opportunity for each person to explore their voice hearing experience. This would normally begin by establishing when the voice started this week and looking at some of the possible stressors that may have occurred at the same time. This may be a very useful time to introduce the concept of stress vulnerability and how voice hearing commonly occurs during periods of very high stress, and is a more common experience than is realised. Having established what stresses made the voices start, the group could explore what the consequences were of hearing voices.

At this stage the group is not looking at the first episode of voice hearing but what is triggering the voices over the last week. The group can then explore what behaviour the group members' use when the voice hearing starts and explore what coping mechanisms they are using to combat the negative effects of the voices. The sharing of this information seems to be very important partly because many of the voice hearers do not realise they have coping mechanisms and partly because it is useful to share other peoples' coping mechanisms.

At this early stage the emphasis may well be on learning and the group can be supplied with several very useful pamphlets (Baker, 1995 and Downs, 2001) as well as on-line leaflets by David Kingdon and the Mental Health Foundation. As confidence grows in the group an exploration of the origin of the voices can be made. This part of the group process needs extreme sensitivity and facilitators need to be very careful about the pace at which this exploration is made as some members relive past trauma. Our groups have been very supportive and have helped this process to the great benefit of those concerned. During these early weeks it also may be useful to end the session with a relaxation exercise as a way of reducing anxiety although several members are keen to tell jokes and this seems to be as helpful! Fun and good humour seems to be as important as the depth of exploration of the voices. For some people this part of the group work is stressful and it seems that initially they are getting worse before they start to get better. As confidence grows people often start to make changes both in their ability to cope with the voices and in the general quality of their lives. The middle part of the group work is concerned with going over the antecedents, behaviours and consequences of voice hearing. More effective ways of coping with the voices are discovered and discussed within the group. Personal goal setting and plans for the future can be introduced at this stage. We have also set up separate self-harm groups to work with the common phenomena of self-harm in voice hearers, especially women.

As the group progresses, the beliefs about the voices can also be examined. This again requires great sensitivity as often very complex beliefs build up over years of experiencing voices because the person may not have been able to talk to anyone else about it. Some beliefs take the forms that conventional psychiatry would call delusional. These beliefs may have very protective functions for the

voice hearer and should only be challenged if the overall benefit is a reduction in distress for the voice hearer or the prevention of harm. Direct challenging of any of these beliefs is often counter-productive. However, a gentle discussion about a belief by other group members often brings about changes much more quickly than a challenge from one of the group facilitators. It is important for the facilitators to "suspend disbelief" as many voice hearers have truly remarkable stories to tell. So-called delusional material can be explored in time (Kingdon and Turkington, 1991).

Bringing in outside speakers to the group is very helpful. The speaker could be a member of another hearing voices group. Several speakers are available to do this work and responses are usually very good as they are speaking from their own direct experience of the benefit of group work on their own lives. Other speakers that have proved useful are the clinical pharmacist and clinical psychologist. Some of the group members of the Gloucestershire Hearing Voices network are available to talk to new groups about their experiences of the recovering process.

Each session of twelve weeks includes creative work such as affirmation cards, drawing, story telling and so on. This work is based on the ideas of self-esteem building and self-acceptance (Dryden, 1998) and some of these CBT processes are incorporated into the groupwork. The nature of the group work changes with time. There becomes less emphasis on clear CBT approaches such as drawing out the antecedents to a particular voice hearing episode and the consequent beliefs, behaviours and coping processes. A more narrative style develops, that involves facilitators and group members co-operating in forming and reforming members' life stories and how they perceive their "scripts" or unchallenged assumptions of their limitations (Roberts, 2000; Roberts & Holmes, 1999; Vassallo, 1998). The last session of each twelve-week block is spent as a celebration with a meal in a pub!

Evaluation

We initially evaluated the group using a series of measures of social functioning (Birchwood, Smith, Cochrane, Wetton, & Copestake, 1990); psychopathology (Lancashire, 1994) and beliefs about the malevolence of the voices (P. Chadwick, Lees, & Birchwood, 2000; P.D.J. Chadwick & Birchwood, 1995). We found some evidence for a reduction in anxiety, depression and voice hearing (Davis, Coupland, Edgar, & Macdougall, 1997) and in the long term, three members stopped hearing voices and returned to full time work. A qualitative evaluation showed that members appreciated the ability to share their experiences; feel less isolated and more accepted (Coupland, Davis, & Macdougall, 2002). Among the facilitators there was also a high degree of satisfaction in working in a group format and seeing changes taking place in members in a mutually supportive atmosphere.

The national Hearing Voices Network has much to offer including information on local user led hearing voices groups and self help groups and an excellent newsletter "Voices Magazine".
HVN
91 Oldham St.,
Manchester
M4 1LW
Tel/fax 0161 834 5768

Gloucestershire hearing voices groups have their own web site with downloadable resources at: www.hearingvoices.org.uk

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